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April 21, 1997

PPL No. 97-007

All County Medi-Cal Administrative Activities/
Targeted Case Management Coordinators and
Advisory Committee Members

MEDI-CAL ADMINISTRATIVE ACTIVITIES/TARGET CASE MANAGEMENT TRAINING QUESTIONS AND ANSWERS

Enclosed is the response to questions raised during the Medi-Cal Administrative Activities (MAA)/Targeted Case Management (TCM) Training conducted February 13-14, 1997 in San Diego. Please ensure this information is disseminated to appropriate staff in your Local Governmental Agency.

If you have any questions, please contact the Administrative Claiming Unit analyst assigned to your Local Governmental Agency.

Sincerely,

for

Darryl Nixon, Chief
Medi-Cal Benefits Branch

Enclosure

Targeted Case Management: X
Medi-Cal Administrative Activities: X
Policy Effective Date:
Policy Reference:

cc: See next page.

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MEDI-CAL ADMINISTRATIVE ACTIVITIES AND TARGETED CASE MANAGEMENT TRAINING
February 13, 1997

QUESTIONS AND ANSWERS

MEDI-CAL ADMINISTRATIVE ACTIVITIES (MAA) QUESTIONS

1. Has it always been required to do a head count for the Medi-Cal discount percentage every quarter in FY 1995-96? I thought we were told we would only need to do head counts each quarter that we did a new time survey.

   Yes, it has always been required that a head count be done for one full month during each quarter in which the claiming unit intends to claim. Under the MAA system, the time survey may be done once per year during the SDHS designated month. However, the actual head count to determine the Medi-Cal discount percentage must be done for one full month each quarter.

2. If the county welfare department can produce an actual countywide Medi-Cal percentage for a given quarter or year, can that be used for an MAA claim?

   No. If a claiming unit chooses to use the countywide average, it must use the percentages provided by SDHS. See PPL No. 97-004.

3. What if you identify in your MAA Claiming Plan that you are going to use "actual head count" for the Medi-Cal discount percentage for an activity, however, the actual head count was not done properly. Is it appropriate and allowable to use the countywide average as a default if the actual head count was not available?

   The actual head count must be done for one full month during each quarter claimed, if actual head count is the method identified in the MAA Claiming Plan. SDHS have spoken with HCFA about reverting to the countywide average if an actual head count cannot be done. HCFA has stated that the methodology stated in the MAA Claiming Plan is the only methodology that will be accepted until a claiming plan amendment is submitted and approved. Claiming Plan amendments are effective beginning with the quarter in which they are submitted and are not retroactive. This means that if an actual head count was not or cannot be done as stated in the claiming plan, the portion of the claim related to the discounted activity shall be denied.

4. We have programs with special populations having different populations of Medi-Cal clients. As long as the actual head count of Medi-Cal clients can be documented for each population, I assume this methodology will be approved in the MAA Claiming Plan. Who approves the MAA Claiming Plan?

If an actual head count can be done for each population served under a specific activity, these head counts can be combined for the Medi-Cal discount percentage for that activity. The methodology for doing this is illustrated in the MAA Invoice Instructions. The MAA Claiming Plan is first reviewed by SDHS. It is then forwarded to HCFA for review and final approval. When the Claiming Plan has been approved by SDHS and HCFA, a letter will be sent to the submitting LGA, listing allowable MAA for each approved claiming unit.

5. For the actual head count -- If the Medi-Cal number is recorded in the case record, can the actual head count for one quarter be as simple as the following?

Count the total number of clients (Medi-Cal and non-Medi-Cal) seen during the full month.
Count the number of Medi-Cal clients seen during the full month.
Divide the Medi-Cal client number by the total client number to get the Medi-Cal discount percentage.

The calculation described is correct.

6. If we conduct a public media campaign that must be discounted, do we apply a Medi-Cal percentage of persons reached by the campaign (if so, how?) or persons served within the MAA unit?

For these types of campaigns, use of the countywide Medi-Cal average may be more appropriate.

7. If you use actual head count to determine the Medi-Cal discount percentage for three Outreach B campaigns, the countywide average for five Outreach B campaigns, and an actual head count for Transportation, how do you reconcile all these different methodologies into a single rate for the claim? Why can't the same methodology be used to reconcile different head counts between program subcomponents?

Outreach B and Transportation are separate activities. The MAA Invoice allows separate Medi-Cal percentages for separate activities. For a single activity, such as Outreach B, only one Medi-Cal percentage can be entered on the MAA Invoice. The only accepted methodologies for determining that percentage is actual head count or countywide average. These two methodologies cannot be combined to arrive at a single Medi-Cal percentage. Refer to PPL No. 96-032.

In the example presented above, the option is to divide the outreach campaigns into two separate claiming units if performed by different staff and if costs for each unit can be segregated. The first claiming unit would include the three Outreach B campaigns for which actual head counts are done. The second claiming unit would include the five Outreach B campaigns for which the countywide average will be used. This would require an amendment to the LGA's MAA Claiming Plan. Amendments to the MAA Claiming Plan are effective from the quarter in which they are submitted. Refer to PPL No. 96-015.

8. Regarding Outreach A -- How do we "document" that we have encouraged someone to apply for Medi-Cal benefits? If we state that we do this in the MAA Claiming Plan, does that suffice? What more is needed?

The MAA Claiming Plan requires a signed certification statement that includes the following language: "I am certifying that the information provided herein is true and correct and accurately reflects the performance of the Medi-Cal Administrative Activities described in the claiming plan."

It is not possible to document what is said by an outreach worker to each person contacted. However, each outreach worker must understand the requirements for claiming Outreach A as stated in the MAA Claiming Plan and conduct such outreach accordingly. Outreach materials used to support the claiming of Outreach A must contain information on how to apply for Medi-Cal and/or how to access Medi-Cal services. "Medi-Cal brochure"

9. Does outreach include outreach to providers regarding encouraging and referring their clients to Medi-Cal eligibility offices and Medi-Cal service providers?

This will be a subject of a forthcoming PPL.

10. Do I have to direct charge for Medi-Cal Non-Emergency, Non-Medical Transportation or can I instead have time I spend arranging transportation placed under this activity on the time survey? The amount of money spent on actual provision of transportation does not seem great enough to warrant direct charging.

Claiming the actual cost of providing transportation through direct charging is optional. It is possible to only claim, through the time survey process, the time spent arranging and/or providing transportation. If a claiming unit chooses not to direct charge the actual cost for staff mileage incurred in transporting Medi-Cal clients to Medi-Cal covered services, staff mileage costs can be included under Other Costs on the MAA Invoice. These costs will then be factored by the MAA activity percentages and appropriate Medi-Cal percentages.

11. Are paratransit providers eligible to participate in MAA?

Yes, to the extent that the service provided is non-emergency, non-medical transportation.

12. Regarding Program Planning and Policy Development (PP&PD) -- What is the status of doing PP&PD less than full time?

This issue is in the MAA TCM Advisory Committee/SDHS Work Plan. It is scheduled to be discussed in April 1997.

13. Wouldn't it be easier to time survey people who are 100% PP&PD rather than keeping separate documentation and logs?

In the MAA Claiming Plan, claiming units are required to explain how time and costs will be determined for PP&PD. While persons performing PP&PD, 100% of their paid work hours are not required to time survey, this method could be proposed for determining time spent on general administration as well as documenting all other time spent on PP & PD.

14. Are there any restrictions regarding direct charging for PP&PD related to the planning and implementation of local Medi-Cal Managed Care Programs?

The MAA Claiming Instructions state that "In counties with county-wide managed care arrangements, program planning and policy development activities are claimable as MAA only for those services that are excluded from the managed care contracts."

Some LGAs received start up grants for planning managed care programs. Claiming PP&PD in these cases may constitute duplicate billing. In cases where the LGAs PP & PD costs exceed the start up grant, the difference may be claimable as MAA, therefore, the LGA may chose to submit a PP & PD MAA Claiming Plan for consideration. Each LGA must review its' managed care contract to determine what ongoing PP&PD is included in the managed care rates.

15. I do not know who to complain to or question. It is ridiculous to send a signed checklist with our TCM and MAA invoices. More paperwork to hold up claims!

The development of these checklists was originally proposed to SDHS as a required tool that could be used by the MAA/TCM Coordinators to review claims prior to submittal to the state. If completed properly by LGAs, this checklist will facilitate the SDHS processing of TCM/MAA Invoices.

16. Docs Mental Health still come under the responsibility of the MAA/TCM Coordinator?

The MAA/TCM Coordinator or designee is responsible for overseeing MAA claiming done through the LGAs contract with SDHS. MAA claiming for Mental Health is now done through the state Department of Mental Health (DMH) and is included in the contract between the LGA and DMH. Each LGA must decide if the MAA/TCM Coordinator or designee will assume the responsibility for overseeing Mental Health claiming for MAA.

TARGETED CASE MANAGEMENT (TCM) QUESTIONS

1. If a program time surveyed in September 1996, but did not file a TCM Cost Report, can they now file that Cost Report?

No. TCM Cost Reports are filed once per fiscal year to establish the TCM encounter rate. If a program area, such as Public Guardian, did not file a TCM Cost Report by the due date for the fiscal year, this program cannot claim for TCM during that fiscal year.

2. A TCM Cost Report has been approved and a rate established for Public Health for FY 1996-1997. A new subunit within Public Health has recently begun providing TCM services. Can this subunit bill TCM encounters during FY 1996-97?

Yes. The established TCM encounter rate applies to all sub-units of Public Health. All sub-units must accept the established Public Health TCM encounter rate. Adding a sub-unit mid-year may cause the LGA to exceed their cap for the year, in which case some encounters would not be reimbursed, that FY. However, the costs associated with the excess encounters would be carried over to the next FY and included in the calculations of the subsequent FY's rate.

3. Do we still have the requirement to submit TCM claims within the six-month time period if the TCM Cost Report has not been approved?

As there have been delays in approving TCM Cost Reports it has not been possible to enforce the six-month limit for FY 1995-96 and FY 1996-97 TCM claims. Enforcement of the six month billing limitation set forth in the Welfare and Institutions Code 14115 (a) will be the subject of a forthcoming PPL.

4. The case manager makes a face-to-face contact and does an assessment. It is found that the case manager is able to manage the problem during the visit and determines that no follow-up is needed. The assessment is documented. Can this be billed as a TCM encounter?

A TCM encounter must include one or more TCM service components. An assessment is a TCM service component. If the client requires no further assistance at the time, the assessment can be billed as a TCM encounter and development of a service plan is not required. This information must be documented in the client case file.

5. Is it true that Public Guardian case managers can claim a TCM encounter for time spent working with doctors or family members on behalf of the client? Specifically, a family member acts on behalf of the client when the client is not competent to act on his/her own behalf. A doctor may act on behalf of the client when there is no family member to serve this function.

The MAA/TCM Manual defines an encounter for Public Guardian as a face-to-face encounter or significant telephone contact with or on behalf of the Medi-Cal eligible person for the purpose of rendering one or more TCM service components by a case manager. The manual does not define categories of persons who might be considered acting on behalf of the client. It is the responsibility of the Public Guardian program to determine who can appropriately act on behalf of a client. This information must be documented in the client case file stating who was acting on behalf of the client.

6. We need some written clarification of the exception to the "face-to-face" requirement for Public Guardian encounters.

The MAA/TCM Provider Manual defines an encounter ***for Public Guardian/Conservator Programs*** *as a "face-to-face encounter or significant telephone contact with or on behalf of the Medi-Cal eligible person for the purpose of rendering one or more TCM service components by a case manager."* ***In the Public Guardian/Conservator environment****, the client is often deemed not competent to participate in the development of the service plan, discuss objectives, or address his/her changing service needs. Therefore, we allow the case manager to record, as a billable encounter, a significant telephone contact with someone acting on behalf of such a client.* ***For the public guardian case documentation purposes****, the case file must contain information relative to the name and relationship of the person acting on behalf of the client, as well as the reason(s) why a face-to-face contact with the client could not be conducted. In no situation is it permissible for a* ***public guardian case manager*** *to claim, as a billable encounter, a significant telephone contact* ***with or on behalf of*** *the Medi-Cal eligible client without documenting the case file as to why the face-to-face encounter with the client could not be conducted.*

7. If a case manager begins working with a client who has had an assessment and/or service plan done previously by another case manager is it necessary to repeat these components in order to begin billing encounters for other TCM service components?

No. If the assessment and/or service plan identifies and addresses the same medical, social, educational or other service needs of the client, the case manager can assume responsibility for the ongoing implementation of the service plan, follow-up, and periodic reassessment. TCM encounters can be billed for these components. The previous assessment and service plan must be referenced in the case manager's notes and incorporated in the client case file.

8. Can an encounter be claimed for an infant who is not at home with the mother if the case manager assesses and discusses plans for the infant in a face-to face contact with the mother?

Yes. The target population for Public Health includes infants and children. Although not explicitly stated, it is implicitly assumed the mother is acting on behalf of the child.

9. For close contact follow-up to tuberculosis there is a mandated care plan which each contact follows. For example, all positive skin tests get referrals and care coordination to ensure X-rays and all children get referred for a medical evaluation and medications. Can't a standard care plan which covers protocol for follow-up be placed in the chart to apply to all situations? There would still be separate recording for each individual regarding their assessment, barriers to care, follow-up status, etc.

It is important to recognize that TCM is a comprehensive program that consists of case management that assists clients to gain access to needed medical, social, educational, and other services. Follow-up that only addresses tuberculosis related treatment is not TCM. TCM requires a broader assessment and service plan. It may be appropriate for the tuberculosis standard care plan to be included in the client's chart to cover one aspect of the broader service plan.

10. Does retroactive Medi-Cal change the status of an encounter even if the first submittal is denied?

With retroactive Medi-Cal the initial encounter may be denied as the client is not yet listed as eligible in the state's records. These encounters should be resubmitted, depending on the month of the encounter (as reported on the TCM claim) and the month of Medi-Cal coverage.

11. When a family unit is being case managed and each family member is a TCM client, is it necessary to have separate charts? Or, can there be one record for the entire family?

It is not necessary to maintain separate charts if it is the LGAs policy to maintain a single family record. However, in order to bill TCM encounters for each family member, each family member must have his/her own documented assessment and service plan. Documentation for each encounter must clearly identify the client for whom the encounter is to be billed.

12. Why does a supervisor need to sign all service plans if the case manager is a professional, e.g., a Public Health Nurse?

The TCM case managers' qualifications were developed with LGA input to accommodate a broad spectrum of practices within programs. None of the State Plan Amendments for TCM require that a case manager be a skilled professional medical person (SPMP). The signature is required to provide quality assurance that the client is being appropriately managed and that the TCM program requirements are being met.

13. In the handout on the TCM Service Plan it states that the case manager and the client collaborate and mutually agree on the plan. Does the client need to be present while the case manager is developing the plan to bill an encounter? If the client does not agree with the plan, can the time spent be billed as an encounter?

The service plan is based on the assessment and consultation ***with the client****. The case manager may actually write the service plan when the client is not present. Although this activity may be time surveyed as TCM, it is not billable as an encounter. When the case manager discusses/reviews the service plan* ***with the client*** *present, this time is billable as an encounter. The client has the right to disagree with the plan and/or to choose not to accept the referrals or continued case management. Even if the client does not accept the service plan, the time spent reviewing the plan* ***with the client*** *is billable as an encounter.*

14. What about TCM encounters provided to people in inpatient hospital settings, jails, etc. A PPL addressed MAA in these settings, but not TCM.

No Medi-Cal payment, including TCM payments, can be made for individuals who are inmates of Public Institutions, such as jails, or who are inpatients institutionalized in Institutes for Mental Disorders (IMDs) for more than 24 hours. (Reference: SDHS/HCFA Agreement)

TCM encounters in hospital inpatient settings are subject to the same restrictions regarding duplicate claiming. More information is needed from the jurisdictions regarding the circumstances in which this may occur.

15. Is TCM provided to a Medi-Cal client who is eligible for a limited range of services in an emergency situation such as emergency services, pregnancy related services, or sensitive services to teens eligible for reimbursement?

Yes. As long as it meets all the criteria for a TCM encounter.

16. Must the TCM Performance Monitoring Plan assure that there is coordination between two or more case managers who provide and bill TCM services, or must the plan assure that any case management services are not duplicated? Is the intent of the plan to only prevent duplication of case management services reimbursed through Medi-Cal?

The intent of the TCM Performance Monitoring Plan is to assure non-duplication of case management services provided through the Medi-Cal reimbursed TCM program.

17. How will the state identify any potential duplication of TCM services? How will the state call that duplication to the LGA's attention?

The state will periodically run reports to identify encounters billed for the same program, as well as the same client by more than one TCM program area, e.g., Public Health and Public Guardian.

18. Is the TCM Summary Invoice also to be submitted on disk?

No. The TCM Summary Invoice is to be submitted on the LGA's letterhead and must accompany the claims disk.